REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

File Number:_____

You have the right to request to inspect your protected health information in records which Medi-Cal creates or maintains. You also have the right to request copies of those records. You will be charged for the cost of copying and postage. You will receive a response to your request within 30 days after we receive your request. If you want copies of your records mailed, you need to send us a photocopy of your California driver's license, Department of Motor Vehicles Identification Card, or other valid identification. You will also need to send documentation verifying your address. Mail this completed form to:

Department of Health Services
EDS/Provider Communications
P. O. Box 526018
Sacramento, CA 95852-6018

<table>
<tr><th colspan="4">INDIVIDUAL INFORMATION</th></tr>
<tr><td colspan="2">LAST NAME:</td><td>FIRST NAME:</td><td>MIDDLE INITIAL:</td></tr>
<tr><td colspan="2">ADDRESS:</td><td>CITY/STATE:</td><td>ZIP CODE:</td></tr>
<tr><td colspan="2">BENEFICIARY ID NUMBER:</td><td colspan="2">DATE OF BIRTH:</td></tr>
<tr><td>DAYTIME TELEPHONE NUMBER:
( )</td><td>EVENING TELEPHONE NUMBER:
( )</td><td>EMAIL ADDRESS:</td><td>BEST HOURS TO REACH YOU:</td></tr>
<tr><th colspan="4">PROTECTED HEALTH INFORMATION YOU WANT TO ACCESS</th></tr>
<tr><td colspan="4">WHAT TYPE OF PROTECTED HEALTH INFORMATION DO YOU WANT TO ACCESS?</td></tr>
<tr><td colspan="4">☐ SUMMARY OF PAYMENTS MADE BY MEDI-CAL (CLAIM DETAIL REPORT)
☐ CASE MANAGEMENT RECORDS
☐ TREATMENT AUTHORIZATION REQUESTS
☐ OTHER _____
☐ OTHER _____</td></tr>
<tr><td colspan="4">PLEASE BE SPECIFIC AS YOU WILL BE CHARGED FOR EACH PAGE COPIED.</td></tr>
<tr><td colspan="4">FOR WHAT TIME PERIOD DO YOU WANT INFORMATION?</td></tr>
<tr><td colspan="2">FROM DATE:</td><td colspan="2">TO DATE:</td></tr>
</table>

METHOD TO ACCESS YOUR PROTECTED HEALTH INFORMATION

☐ PLEASE MAIL ME A COPY OF THE REQUESTED INFORMATION.

☐ I WISH TO REVIEW THE REQUESTED INFORMATION IN PERSON.

☐ I REQUEST THAT A PERSON OF MY CHOOSING BE ALLOWED TO INSPECT MY RECORDS.

NAME:

TELEPHONE NUMBER: ( )

ADDRESS:

RELATIONSHIP TO YOU:

IF YOU REQUEST TO REVIEW RECORDS IN PERSON YOU WILL BE CONTACTED TO SCHEDULE AN APPOINTMENT.

LOCATION AVAILABLE FOR IN-PERSON REVIEW: **SACRAMENTO ONLY**

IDENTIFYING INFORMATION

☐ COPY OF IDENTIFICATION ATTACHED

TYPE:_____ (CA DRIVER'S LICENSE, CA DMV IDENTIFICATION CARD, BIRTH CERTIFICATE, BENEFICIARY IDENTIFICATION CARD, MANAGED CARE CARD, STATE OR FEDERAL EMPLOYEE ID CARD)

NUMBER:_____

I DECLARE UNDER PENALTY OF PERJURY THAT THE INFORMATION ON THIS FORM IS TRUE AND CORRECT.

BENEFICIARY SIGNATURE: DATE:

(IF NO IDENTIFICATION IS ATTACHED YOUR SIGNATURE MUST BE NOTARIZED.)

NOTARIZED BY: _____ ON _____(DATE)

NOTARY PUBLIC NUMBER: _____

UNOFFICIAL UNLESS STAMPED BY NOTARY PUBLIC:

☐ ADDRESS VERIFICATION ATTACHED

FORM OF ADDRESS VERIFICATION _____ (UTILITY BILL, PHONE BILL, DRIVER'S LICENSE, ETC.)

NOTE: ANY ATTEMPT TO FALSELY GAIN ACCESS TO PROTECTED HEALTH INFORMATION IS SUBJECT TO LEGAL PENALTIES.